the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture applicable to payments made to facilities prior to reimbursement under the FRVS shall be determined as follows:

(a) The gross recapture amount shall be the lesser of the actual gain on the sale allocated to the periods during which depreciation was paid or the accumulated depreciation after the effective date of January 1, 1972 and prior to the implementation of payments based on FRVS to the facility. The gross recapture shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program. Additional beds and other related depreciable assets put into service after April 1, 1983 shall be subject to the same 12 1/3 year depreciation recapture phaseout schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by 1.00 percent for each month in excess of 48 months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sales price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sale Price: $6,000,000
Older Portion of facility:
Number of beds = 60

Newer portion of facility:	
Number of beds = 120	
Allocation to older portion: (60/180) x 6,000,000 =	$2,000,000
Allocation to new portion: (120/180) x 6,000,000 =	$4,000,000
Sale Price	$6,000,000

(b) The adjusted gross recapture amounts as determined in (a) above shall be allocated for fiscal periods from January 1, 1972, through the earlier of the date of sale, or the implementation of payments based on the FRVS for the facility. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(c) The net recapture overpayment amount, if any, so determined in (b) above shall be paid by the former owners to the State. If the net recapture amount is not paid by the former owner, in total or part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

2. Depreciation recapture resulting from leasing facility or withdrawing from Medicaid program. In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the time he was the Medicaid provider

shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated, licensed operator after having operated the facility as a licensed Medicaid provider. After April 1, 1983, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the Agency creating an equitable lien on the owner's nursing home assets. This lien shall be filed by the Agency with the clerk of the Circuit Court in the Judicial Circuit within which the nursing home is located. The contract shall specify the method for computing depreciation recapture, in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the Agency upon sale of the facility. In the event that an owner-provider withdraws from the Medicaid program, the reduction in the gross depreciation recapture amount calculated in Section III. H.1. (a) above shall be computed using only the number of consecutive months that the facility is used to serve Medicaid recipients. EXAMPLE: An owner-operator participates in Medicaid for 60 months. He then withdraws from the Medicaid program and leases the facility to a new operator, who enters the Medicaid program as a new provider and participates for 24 months. At the end of the 24 months, the lessee withdraws from the Medicaid program and operates the facility for another 5 years, after which the owner sells the facility. The gross recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the 60 months that he was the provider. The reduction in the gross recapture amount will be (60+24 - 48) months times 1.00 percent. If a provider fails to sign and

return the contract to the Agency, the new license for the prospective operator of the facility shall not be approved.

I. Recapture of property cost indexing above the FRVS base paid under the fair rental value method.

1. Reimbursement due to indexing paid under the FRVS shall be defined as the accumulated reimbursement paid due to the difference between the FRVS rates paid and the initial FRVS rate established for the facility.

2. Upon sale of assets recapture of reimbursement due to indexing under FRVS shall be determined as follows:

   (a) The total amount of indexing shall be recaptured if the facility is sold during the first 60 months that the facility has been reimbursed under FRVS;

   (b) For months 61 and subsequent, 1 percent of the recapture amount shall be forgiven per month. Two percent of the recapture amount shall be forgiven per month if the facility had Medicaid utilization greater than 55 percent for a majority of the months that the facility was reimbursed under FRVS; and

3. Documented costs of replacement equipment purchased subsequent to FRVS payments and for which additional payments were not made per Section V.E.1.j. shall reduce dollar-for-dollar the amount of recapture, but shall not create a credit balance due to the provider.

J. Return on Equity.

A reasonable return on equity (ROE) for capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of this plan as an allowable cost. This return on equity shall use the

principles stated in Chapter 12, CMS-PUB.15-1 (1993) except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Medicaid Program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis. For facilities being reimbursed under FRVS for property, positive equity in capital assets shall be removed from the owners' equity balance in computing ROE. A full return on equity payment shall be calculated on 20 percent of the FRVS asset valuation per Section V.E. 1.e. of this plan and included in the FRVS rate.

K. Use Allowance.

A use allowance on equity capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed for non-profit providers except those that are owned or operated by government agencies. This use allowance shall use the principles stated in Chapter 12, CMS-PUB.15-1 (1993) established in Section J. above, but shall be limited to one-third of the rate given to profit-making providers. For facilities being reimbursed under the FRVS method for property costs, including governmentally owned or operated facilities, all provisions of J. above, including the full rate of return, shall be used in computing the use allowance for the property-related equity and included in the FRVS rate.

L. Legal Fees and Related Costs.

In order to be considered an allowable cost of a provider in the Florida Medicaid Program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other

fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If, on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal, as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA, relating to Medicaid audits, Medicaid cost reimbursement cases, including administrative rules, administrative rules affecting Medicaid policy, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

M. For nursing homes participating (obtaining liability insurance coverage) in a risk-retention group (RRG) that meets the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 and is approved by the Department of Insurance in the state in which the RRG is domiciled, the initial capital contribution for a nursing facility will be an allowable administrative cost in the nursing facility's Medicaid cost report. The capital contribution portion of the premium reimbursed by Medicaid shall be limited to $1000 per bed.

N. Effective January 1, 2002, the direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses,

licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. Direct care staff does not include nursing administration, MDS, and care plan coordinators, staff development, and staffing coordinator.

Effective January 1, 2002, all other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office or management company for staff who do not deliver care directly to residents in the nursing home facility.

Providers on budget at the January 1, 2002 rate setting will not be required to submit a supplemental schedule. The Agency for Health Care Administration will divide the interim patient care costs into direct and indirect subcomponents based on a 65% and 35% split, respectively. The patient care split will be subject to settlement upon receipt of their initial cost report.

IV. Standards

A. In accordance with Section 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. For purposes of establishing reimbursement ceilings, each nursing home within the State shall be classified into one of six reimbursement classes as defined in V. A.3 of this plan. Separate reimbursement ceilings shall be established for each class. Separate operating and patient care reimbursement ceilings shall be established for each class, but the property cost component shall be subject to a statewide reimbursement ceiling for facilities still being reimbursed depreciation and interest per Section III.G. 3.-5.

C. The ceilings shall be determined prospectively and shall be effective semiannually, on January 1 and July 1. The most current cost reports postmarked or accepted by a common carrier by October 31 and April 30 and received by November 15 and May 15, respectively, shall be used to establish the operating and patient care class ceilings. Beginning with the January 1, 1988, rate period additional ceilings based on the Target Rate System shall also be imposed. Beginning with the July 1, 1991 rate period, additional ceilings for new providers shall also be imposed. The first cost report submissions for all newly constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end of these newly constructed facilities shall be after October 1, 1977. In addition, all facilities with year ends prior to that of the one hundredth facility in an array from most current to least current year end shall not be considered in setting the property cost ceilings. Ceilings shall be set at a level, which the State determines to be adequate to reimburse the allowable and reasonable costs of an economically and efficiently operated facility. The property ceiling for facilities being reimbursed per Section III.G.3.-5. of this plan pending transition to payments based on the FRVS shall be the ceiling in effect at July 1, 1985. The operating and patient care class ceilings shall be the maximum amount paid to any provider in that class as reimbursement for operating and patient care costs. Establishment of prospective class ceilings and an individual provider's reimbursement rate will reasonably take into account economic conditions and trends during the time periods covered by the payment rates. A provider shall be exempt from the operating and patient care class ceilings and target rate ceilings if all of the following criteria are satisfied:

a) All of the resident population are dually diagnosed with medical and psychiatric conditions.

b) No less than 90 percent of the resident population suffers from at least one

of the following: severe behavioral, emotional, or cognitive difficulties resulting from their psychiatric impairment.

c) The facility provides clinically appropriate care to address these behavioral, cognitive, and emotional deficits.

d) A medically approved individual treatment plan is developed and implemented for each patient. The plan comprehensively addresses the client's medical, psychiatric, and psychosocial needs.

e) The facility complies with the licensure provisions for specialty psychiatric hospitals in accordance with Rule 59A-3 FAC.

f) The facility complies with HRSR 95-3 with regard to psychotropic drugs or establish written facility standards that meet or exceed this regulation.

g) The facility complies with HRSM 180-1 with regard to quality assurance procedures or establishes written facility standards that meet or exceed this regulation.

Beginning on or after January 1, 1984, provider whose reimbursement rates are limited to the class ceiling for operating and patient care costs shall have their reimbursement exceeded under the circumstances described below. The provider must demonstrate to the Agency that unique medical care requirements exist which requires extraordinary outlays of funds causing the provider to exceed the class ceilings. Circumstances which shall require such an outlay of funds causing a provider to exceed the class ceilings as referenced above shall be limited to:

a) Acquired Immune Deficiency Syndrome (AIDS) diagnosed patients requiring isolation care;

b) Medically fragile patients under age 21 who require skilled nursing care.

The period of reimbursement in excess of the class ceilings shall not exceed 6 months. A flat rate shall be paid for the specific patients identified, in addition to the average per diem paid to the facility. The flat rate amount for AIDS patients shall include the costs of incremental staffing and isolation supplies, and shall be trended forward each rate semester using the DRI indices used to compute the operating and patient care ceilings. The flat rate payment for Medically fragile patients under age 21 who require skilled nursing care shall be the same as the flat rate payment for "grandfathered in" ventilator patients, and shall be trended forward using the DRI indices in the same manner as the payment for AIDS patients. Patients requiring the use of a ventilator and related equipment whose costs were approved under the 10/1/85 reimbursement plan shall be "grandfathered in"--that is, a flat rate shall be paid for incremental staffing costs only. Costs of the ventilator and related equipment, that is, rent, depreciation, interest, insurance and property taxes, shall be paid in addition to the flat rate. No new ventilator patients shall be approved for payment above the ceilings as of the effective date of this plan. Ventilator patients that have their Medicaid eligibility canceled and later reinstated will no longer be "grandfathered in." Instead, they are considered to be new ventilator patients. These incremental costs shall be included in the cost reports submitted to AHCA, but shall not be included in the calculation of future prospective rates. The incremental costs of staffing and isolation supplies for AIDS patients, incremental costs of staffing for ventilator patients, and the cost of Medically fragile patients under age 21 who require skilled nursing care, shall be adjusted out based upon the flat rate payments made to the facility, in lieu of separately identifying actual costs. The cost of ventilators and related equipment shall be adjusted out based upon payments made to the facility, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider from the Medicaid Office of Program Development. The class ceilings

may also be exceeded in cases where Medicaid patients are placed by the Agency for Health Care Administration in hospitals or in non-Medicaid participating institutions on a temporary basis pending relocation to participating nursing homes, for example, upon closure of a participating nursing home. The CMS Regional Office shall be notified in writing at least 10 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. AHCA shall extend the class ceiling exception for subsequent 6-month periods upon making a determination that a need for the exception still exists and upon providing the CMS Regional Office with another advance written notification as stated above.

D. Effective October 1, 1985, FRVS shall be used to reimburse facilities for property. To prevent any facility from receiving lower reimbursement under FRVS than under the former method where depreciation plus interest costs were used to calculate payments, there shall be a transition period in which some facilities shall continue to be paid depreciation plus interest until such time as FRVS payments exceed depreciation and interest payments as specified in Section V.E.1.h. At that time, a facility shall begin reimbursement under the FRVS. Facilities entering the program after October 1, 1985 that had entered into an armslength (not between related parties) legally enforceable agreement for construction or purchase loans prior to October 1, 1985 shall be eligible for the hold harmless clause per Section V.E.l.h.

E. The prospectively determined individual nursing home's rate will be adjusted retroactively to the effective date of the affected rate under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rate.

2. A provider submits an amended cost report used to determine the rate in effect. An adjustment due to the submission of an amended cost report shall not be

granted unless the amended cost report shall cause a change of 1 or more percent in the total reimbursement rate. The provider shall submit documentation supporting that the 1 percent requirement is satisfied. This documentation shall include a rate calculation using the same methodology and in a similar format as used by the Agency in calculating rates. The amended cost report shall be filed by the filing date of the subsequent cost report or the date of the first field audit exit conference for the period being amended or the date a desk audit letter is received by the provider for the period being amended, whichever is earlier.

3. Further desk or on-site audits of cost reports disclose a change in allowable costs in those reports.

4. The section shall not apply to the case-mix adjustment calculated in Section V.G. of this plan.

F. The Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's allowable Medicaid costs divided by the Medicaid patient days from the most recent cost report subject to the rate setting methodology in Section V. of this plan.

G. Reimbursement of operating and patient care costs are subject to class ceilings. Property costs are subject to statewide ceilings, which shall be the ceilings computed at July 1, 1985, for facilities being reimbursed under Section III.G.3.-5. of this plan. For facilities being reimbursed under FRVS, the cost per bed ceiling shall be per Section V.E.1.g. of this plan. Return on equity and use allowance are passed through and are not subject to a ceiling.

H. An incentive factor is available to providers whose operating per diems are under the class ceiling and who have provided quality of care resulting in standard ratings on the license issued by AHCA pursuant to the provisions of Rule 59A-4.128, F.A.C.

Additional incentive is available for providers who have been granted superior quality of care licensure ratings. Beginning with the July 1, 1996, rate semester, incentive factor payments will no longer be made and a Medicaid Adjustment Rate shall be made pursuant to Section V.F. of this plan.

I. A low occupancy adjustment factor shall be applied to costs of certain providers.

J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process.

1. Requests for rate adjustments to account for increases in property-related costs due to capital additions, expansions, replacements, or repairs, or for allowable lease cost increases shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specified expansion, addition, replacement, allowable lease cost increase or repair would cause a change of 1 percent or more in the provider's total per diem reimbursement rate. For facilities being reimbursed under FRVS, property-related costs shall not be considered in any interim rate request. Adjustments to FRVS rates for property-related costs shall be made only on January 1 and July 1 of each year per Section V.E.1.j.

2. Interim rate changes reflecting increased costs occurring as a result of patient care or operating changes shall be considered only if such changes were made to comply with existing State or Federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1 percent or more in the provider's current total per diem rate.

(a) If new State or Federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes

that result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by the Agency and shall be the basis for establishing reasonable cost parameters.

(b) In cases where new State or Federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

3. Interim rate adjustments shall not be granted to reflect increases in the cost of general or professional liability insurance for nursing homes unless the following criteria have been met:

a) The nursing home must have at least a 65 percent Medicaid utilization in the most recent cost report submitted to the Agency;

b) The increase in general or professional liability costs to the facility for the most recent policy period affects the total Medicaid per diem by at least 5 percent;

c) This rate adjustment shall not result in the per diem exceeding the class ceiling; and

d) This provision shall l be implemented to the extent that existing appropriations are available.

4. Interim rate requests resulting from 1., and 2. above must be submitted within 60 days after the costs are incurred, and shall be accompanied by a l2-month budget that reflects changes in services and costs. For providers being reimbursed under

FRVS, interim rate adjustments due to capital additions or improvements shall be made per Section V.E.1.j. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate received after August 31, 1984, the AHCA Office of Medicaid shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid shall approve or disapprove the interim rate request within 60 days. If the AHCA office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement. Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual costs shall be paid to the provider.

6. Interim rates shall not be granted for fiscal periods that have ended.

7. Interim rates for the additional staffing requirements effective January 1, 2002 shall not be granted. For providers incurring additional costs to meet the new minimum staffing standards, a "gross-up adjustment" as described in section V.B 4 will be used. For costs incurred prior to January 1, 2002 by providers who

have submitted the supplemental schedule, the following methodology will be used:

November 2001 = 50% of the additional costs as computed in section V.B4 on a daily per diem basis times the number of days in November that costs were incurred to meet the January 1, 2002 staffing requirements shall be reimbursed;

December 2001 = 75% of the additional costs as computed in section V.B4 on a daily per diem basis times the number of days in December that costs were incurred to meet the January 1, 2002 staffing requirements shall be reimbursed.

No costs will be recognized by providers incurring additional costs to meet the new minimum staffing standards prior to November 1, 2001.

K. The following applies to rate periods prior to July 1, 1985: In the event that a provider receives a new licensure rating making him eligible or ineligible for any amount of incentive payments, his prospective reimbursement rate shall be changed to reflect his new licensure rating and shall be effective beginning on the first day of the month after the month in which the new licensure rating became effective. For rates effective on or after July 1, 1985, the incentive payments based on licensure ratings shall be calculated according to the provisions of Section V.D. below.

L. Effective April 1, 1999 there will be a case-mix adjustment, which will be paid as an add-on to the patient care component of the provider's total reimbursement rate. The amount of the case-mix adjustment will be calculated pursuant to Section V.G. of this plan. Effective January 1, 2002, the case-mix adjustment will be eliminated

M. For nursing homes participating (obtaining liability insurance coverage) in a risk-retention group (RRG) that meets the criteria established under the provisions of the

federal Liability Risk Retention Act of 1986 and is approved by the Department of Insurance in the state in which the RRG is domiciled, the Agency will advance the initial capital contribution portion of the total premium assessed against the nursing facility.

N. Effective January 1, 2002, providers will be required to complete a supplemental schedule from the Medicaid cost report filed to be used in the January 1, 2002 rate setting. The information reported on the supplemental schedule will be used to rebase the patient care component of the Medicaid per diem rate and to calculate a "gross-up adjustment" to facility rates at January 1, 2002 for the increased staffing requirements.

O. Aggregate Test Comparing Medicaid to Medicare 42 CFR 447.253(b)(2) (1994) provides that states must assure the The Centers for Medicare and Medicaid Services that "The Medicaid agency's estimated average proposed payment rate...pay no more in the aggregate for...long-term care facility services than the amount that...would be paid for the services under the Medicare principles of reimbursement." At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare reimbursement principles, the following steps shall be taken for that rate semester, in order, as necessary to meet the aggregate test:

1. The increase in property reimbursement due to indexing for FRVS shall be reduced until the upper limit test is met for that rate semester. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below the initial per diem the provider received under FRVS. This per diem is inclusive of all components of FRVS, including property, return on equity, taxes and insurance.

2. Any incentive payments or other payments that exceed the projected cost rate shall be reduced on a pro rata basis until Medicaid aggregate payments are equal

to or less than the amount that would be paid for services under the Medicare reimbursement principles.

3. If provisions 1 and 2 are implemented in order to meet the upper limit test, for a period of 1 year, this plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

P. Payments made under this plan are subject to retroactive adjustment if approval of this plan or any part of this plan is not received from the federal Centers for Medicare and Medicaid Services (CMS). The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this plan not authorized by CMS.

V. Method

This section defines the methodologies to be used by the Florida Medicaid program in establishing reimbursement ceilings and individual nursing home reimbursement rates.

A. Ceilings.

1. Ceilings shall be determined prospectively and shall be effective semi-annually on January 1 and July 1. The most current acceptable cost reports postmarked or accepted by a common carrier by October 31 or April 30 and received by November 15 or May 15, respectively, of each year and the provider's most recent reimbursement rates shall be used to establish the operating and patient care ceilings. More current cost reports shall be used to establish rates if production time permits. The first cost report submissions for all newly constructed facilities shall be used to establish the property cost ceiling. The first cost report year-end for these newly constructed facilities must be after October 1, 1977. In addition, all facilities with year-ends prior to that of the one-hundredth facility in an array from most current to least current year end shall

not be considered in setting the property cost ceiling. The ceiling for property computed here shall be used for all facilities not yet being reimbursed under FRVS. The ceiling computed at July 1, 1985 shall be used beginning with July 1, 1985 rates, and all subsequent rates for facilities until they begin receiving reimbursement under FRVS. For those facilities being reimbursed under FRVS, the cost per bed ceiling per Section V.E.1.g. of this plan shall be used.

2. For the purpose of establishing reimbursement limits for operating and patient care costs, four classes based on geographic location and facility size were developed. These classes are as follows:

   a. Size 1-100 beds - Northern Florida Counties

   b. Size 101-500 beds- Northern Florida Counties

   c. Size 1-100 beds - Southern Florida Counties

   d. Size 101-500 beds- Southern Florida Counties

   For purposes of defining the four reimbursement classes, the "Southern Florida Counties" shall be comprised of:

Broward	Hardee-	Monroe
Charlotte	Hendry	Okeechobee
Collier	Highlands	Palm Beach
Dade	Indian River	Polk
Desoto	Lee	St. Lucie
Glades	Martin	Sarasota

   All remaining Florida Counties shall be "Northern Florida Counties."

3. As of July 1, 1994, two additional reimbursement classes shall be defined as follows:

   a. Size 1-100 beds - Central Florida Counties

   b. Size 101-500 beds - Central Florida Counties

The "Central Florida Counties: shall be comprised of:

Brevard	Manatee	Pinellas
Hardee	Orange	Polk
Highlands	Osceola	Seminole
Hillsborough	Pasco	

The "Northern Florida Counties" and "Southern Florida Counties" shall be comprised of the counties enumerated in Section V.A.2. less the "Central Florida Counties" as defined above.

4. Nursing homes participating in the Medicaid program as of July 1, 1994, and located in Hardee, Highlands, or Polk County, shall be "grand-fathered in," and shall be considered as members of the "Southern Florida Counties" class, until such time that the "Central Florida Counties" class reimbursement ceilings for the operating cost and patient care cost components equal or exceed the corresponding July 1, 1994, "Southern Florida Counties" class ceilings. The "grandfathered-in" provision shall be applied separately for the operating cost and patient care cost components in each of the two facility size classes. That is, nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the operating cost component until such time as the "Central Florida Counties" operating cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" operating cost component ceiling for that class. Nursing facilities of a given size in Hardee, Highlands, and Polk counties shall be considered as members of the applicable "Southern Florida Counties" size class in the patient care cost component until such time as the "Central Florida Counties" patient care cost component ceiling equals or exceeds the July 1, 1994, "Southern Florida Counties" patient care cost component ceiling.

B. Setting prospective reimbursement per diems and ceilings. In determining the class ceilings, all calculations for Sections V.B. 1. - V. B. 18. shall be made using the four class, and "Northern Florida Counties" and "Southern Florida Counties" definitions of sections V.A. 2. above. All calculations for Sections V.B.19. - V.B.21 shall be made using the six class and "Central Florida Counties" definition of Section V.A.3. above. The Agency shall:

1. Review and adjust each provider's cost report referred to in A.1. to reflect the result of desk or on-site audits, if available.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1997)

3. Determine total allowable Medicaid cost.

4. Determine allowable Medicaid property costs, operating costs, patient care costs, and return on equity or use allowance. Patient care costs include those costs directly attributable to nursing services, dietary costs, activity costs, social services costs, and all medically ordered therapies. All other costs, exclusive of property cost and return on equity or use allowance costs, are considered operating costs. For providers receiving FRVS payments, the return on equity cost or use allowance cost shall be reduced by the amount attributable to property assets, and the FRVS rate shall reflect a return on equity for property assets as per Section III.J. and K.

   a. Effective January 1, 2002, there will be direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Providers will be required to complete a supplemental

schedule for the Medicaid cost report to be used in the January 1, 2002 rate setting. The supplemental schedule shall contain the direct subcomponent of the patient care costs. Providers who do not submit a supplemental schedule shall have all patient care costs allocated into direct care and indirect care subcomponents based on a 65% and 35% split, respectively. Providers who do not submit the supplemental schedule will be excluded from the calculation of patient care ceilings.

Providers who do not submit the supplementary schedule will not have their costs "grossed-up," as detailed in b. below, if their staffing ratios do not meet the mandated minimum staffing standards for January 1, 2002. For providers filing a late supplemental schedule, there will be no retroactive adjustment to direct care or indirect care allocation or to the "gross-up." The late-filed supplemental schedule will not be used until the following prospective January 1 and July 1 rate semesters.

b. For the January 1, 2002 rate semester, each prospective provider's direct care subcomponent will be adjusted for the additional costs incurred by the provider to comply with the minimum staffing requirements for nursing (registered nurses and licensed practical nurses) and certified nursing assistants (CNA's). This adjustment will be based on the information provided by each provider in the supplemental schedule filed with the cost report used to establish the January 1, 2002 Medicaid per diem rate.

The total reported productive hours for registered nurses (RN), licensed practical nurses (LPN), and CNA's will each be divided by the number of total patient days reported. Total reported productive hours include hours for employees of the facility and hours for leased staff. The result will

represent the hours per patient day for each level of nursing service. The productive hours per patient day for RN's and LPN's will be combined for total productive nursing hours per patient day. Gross-up factors will be calculated for nursing hours and CNA hours by dividing the productive nursing hours per patient day into 1.0 and dividing the productive CNA hours per patient day into 2.3. Facility direct care subcomponent nursing costs will be multiplied by the nursing gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. Facility direct care CNA cost will be multiplied by the CNA gross-up factor if the factor is greater than 1.0, and by 1.0 if the factor is less than or equal to 1.0. These adjusted nursing and CNA costs will be added together to obtain the adjusted direct care costs.

The adjusted direct care costs will be used for the purpose of computing ceilings and the prospective per diem rate.

5. Calculate per diems for each of these four cost components by dividing the components' costs by the total number of Medicaid patient days from the latest cost report. For providers receiving FRVS cost reimbursement, substitute the appropriate FRVS per diem as per Section V.E. of this plan.

6. Adjust a facility's operating and patient care per diem costs that resulted from Step B.5 for the effects of inflation by multiplying both of these per diem costs by the fraction: Florida Nursing Home Cost Inflation Index at midpoint of prospective rate period, divided by the Florida Nursing Home Cost Inflation Index at midpoint of provider's cost report period. The calculation of the Florida Nursing Home Cost Inflation Index is displayed in Appendix A. Only providers being paid a prospective rate under section V.B.6. shall be eligible for the